PATIENT REGISTRATION

Patient Info:

Name____Birthdate________Sex:___F___M
Last Name First Name M.Initial Preferred Name

Address______________________________City_____________State_____Zip__________

Home Phone____________________________ Social Security Number__________________

Employer____________________________________ Position________________________

Work Address_________________________________ Work Phone_____________________

Email Address________________________________ Cell Phone______________________

In case of emergency, whom may we contact?____________________ Phone__________________

Whom may we thank for referring you to our office?______________________________________

Responsible Party Info: ___Same as above

Name____Birthdate________Sex:___F___M
Last Name First Name M.Initial Preferred Name

Address______________________________City_____________State_____Zip__________

Home Phone____________________________ Social Security Number__________________

Employer_______________________________________ Position______________________

Work Address____________________________________ Work Phone__________________

MEDICAL HISTORY

Physician's Name____________________________________ Phone____________________

Check if you have or have ever had any of the following:

___Heart Condition
___Heart Murmur
___Blood Disorders
___Abnormal Blood Pressure
___Rhuematic Fever
___Pacemaker
___Artificial Heart Valves
___Artificial Joints/Prosthesis
___Ulcer / Intestinal Problems
___Stroke
___Diabetes
___Asthma
___Respiratory Disease
___Epilepsy / Seizure
___Thyroid Problems
___Venereal Disease
___Jaundice/Liver Disease
___Immune Disorders
___Arthritis
___Tuberculosis
___Hepatitis
___Tested HIV Positive
___Malignancy
___Radiation Therapy
___Psychiatric Care
___Kidney Disease
___Fainting Spells

(Women) Are you pregnant? Y N *Nursing?* Y N *Taking Birth Control Pills?* Y N

Are you currently under the care of a physician? Y N If yes, for what condition?_____________

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Are you currently taking any medications? Y N If yes, which?____________________________

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Do you have any allergies to any medications? Y N If yes, which?_______________________

Have you had any serious illnesses or major surgery? Y N If yes, describe__________________

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Do you have any disease, conditions, or problems not listed? Y N ________________________

Is there anything else we should know about your medical history? ________________________

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Release:

The above information is accurate and complete to the best of my knowledge. I will not hold Paul Hoeft DDS, Kaysville Dental PC, or any staff member responsible for any errors or omissions that I may have made in completion of this form. I authorize Paul Hoeft DDS to perform diagnostic procedures and treatment as necessary for proper dental care. I understand and agree that (regardless of my insurance status) I am financially responsible for payment in full for professional services rendered as well as for any and all collection agency fees should my account become delinquent. Should collection action become necessary, the responsible party or patient if over 18 years of age, agrees to pay an additional 33% collection fee, and all legal fees of collection, with or without suit, including attorney fees and court costs. I understand that interest will accrue from the date of service on accounts over 60 days past due at the rate of 1.5% per month (19.56 % apr).

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Date Signature (Patient or Legal Guardian of Patient) Dentist Signature